Clear Form Entries

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Rehabilitation Supports

AMENDMENT TO THE _____/_____/_____ TREATMENT PLAN

(date)

Please Type or Print

Name: _____ SS#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___
1 2 3 4 5 6 7 8 9

Reason for Change: ☐ Met Goal or Objective ☐ No progress/Limited progress
☐ Consumer Request ☐ Other: _____

My Goal is to improve or retain skills in the following area:

☐ Personal Care ☐ Cognitive/independent living skills ☐ Health and Nutrition
☐ Self-esteem ☐ Personal Responsibility ☐ Coping Skills
☐ Medication Management ☐ Social Skills ☐ Community Living

My objective for reaching my goal in the area noted above is:

Personal Care: _____

Cognitive/independent living skills: _____

Health/Nutrition: _____

Self-esteem: _____

Personal Responsibility: _____

Coping Skills: _____

Medication Management: _____

Social Skills: _____

Community Living: _____

These activities will help me accomplish my objective: _____

_____

_____

I plan to work on this objective: _____ times weekly _____ times monthly

I plan to accomplish this objective by (month/year): _____

Date Services to Begin: _____/_____/_____ 6 month Review Due Date: _____/_____/_____

Consumer: _____ _____

Parent/Guardian (if consumer is a minor): _____ _____

Lead Clinical Staff: _____ _____

6 month Review

Progress made toward accomplishing goal/objective? ☐ Yes ☐ No

Issues pertinent to functioning: _____

_____

Continue Rehabilitation Supports? ☐ Yes ☐ No

LCS Signature: _____ Date: _____